Patient Responsibility Form

MCNA Dental

mcnadental

You must understand and agree to pay for any dental services that MCNA does not cover before you get them. Review the dental services listed below with your dentist. Make sure you understand the planned treatment and how much it will cost. You must sign and date this form before you get any of these dental services. When you sign this form it means **you agree to pay the full amount for the dental services.** If you fail to make each payment you may be subject to collection action.

Dental Office Information

To be completed by the dental office.

Office Name (Business Name)

Provider Name (First, Middle, Last Name, DDS/DMD)

Office Phone Number

Date Treatment Plan Created (MM/DD/YYYY)

Procedure Information

To be completed by the dental office. Use additional sheets as necessary.

Procedure and Tooth/Arch	Fee	Procedure and Tooth/Arch	Fee
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$

Member Information

To be completed by the member, parent, or guardian.

Member ID Number

Member Name (First Name, Last Name)

My dentist let me know that there are **NO** covered services to take care of my dental concern. ☐ **YES** ☐ **NO**

My dentist let me know that there **ARE** covered services that would take care of my dental concern. I am refusing covered services to select these. ☐ **YES** ☐ **NO**

I agree that the dental services and fees on this form are what I talked about with my dentist. ☐ **YES** ☐ **NO**

I AGREE THAT I AM PERSONALLY RESPONSIBLE FOR THE FULL AMOUNT OF THESE SERVICES. ☐ **YES** ☐ **NO**

Patient's Signature
(Parent or guardian signature if patient is under 18 years old)

Print Name

Date (MM/DD/YYYY)